

# Application and Health Questionnaire for Comprehensive Major Medical Preferred-Provider High-Deductible Coverage



## An Individual Preferred-Provider High-Deductible Program

*Highmark Blue Cross Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association*

### How to complete this application:

1. Read all materials provided with this application, including the Outline of Coverage, so that you understand the cost-sharing obligations of the coverage you have selected and to ensure you have selected the health care coverage that is right for you.
2. Tear off this front page along the perforation. **Keep this page for your records.** You may want to refer to it if you have a question about your application or the appeals process.
3. On page 1, provide all "General Information" and all "Enrollment Information" requested. Provide information about your spouse and dependents only if they are also applying for coverage.
4. Provide all "Medical Information" requested under Sections A, B, C and D on pages 2 through 6. Provide information about yourself and each dependent who is also applying.
5. Read the "Conditions of Enrollment" on page 7. Be sure to sign and date where indicated. If both you and your spouse are applying for coverage, both of you must sign and date this application.
6. The "Producer's Certificate" on page 8 should be completed only by an insurance producer acting on your behalf. Do not complete if you are applying on your own.
7. Return your completed application with a check or money order for your initial premium made payable to "Highmark Blue Cross Blue Shield." Mail to:  
Highmark Blue Cross Blue Shield  
P.O. Box 382555  
Pittsburgh, Pennsylvania 15250-8555

#### **Please Note:**

**Receipt of your initial payment does not constitute enrollment under this program. Your coverage will not begin until this application has been accepted by Highmark Blue Cross Blue Shield and you have been notified that an effective date of coverage has been assigned. If your application is approved by the medical underwriting department on or before the last day of the month, your coverage will become effective on the first day of the following month. Failure to provide all the information requested may result in a delay in the processing of your application.**

Keep this page for your records.

Date: \_\_\_\_\_

Check Number: \_\_\_\_\_

Amount Remitted: \_\_\_\_\_

Deductible Amount Applied For: \_\_\_\_\_

## Underwriting your application

The basic source of information we use to determine your eligibility for this insurance policy is your application. Experienced underwriters will carefully and promptly review the information you have provided. In addition, we may also obtain information from other sources, including physicians and hospitals, as authorized by you when you complete your application.

A high percentage of our applicants are in good health and meet our underwriting standards. As a result, these applications are quickly approved and insurance policies are issued. Some applicants, however, present a greater insurance risk, usually due to an abnormal physical condition or history of medical problems. By underwriting policies in this way, we try to keep the cost of health care coverage affordable for as many people as possible.

If, due to your medical history, you do not qualify for coverage at the rate for which you apply, you may be eligible for coverage at a higher rate, as determined in accordance with our medical criteria ("underwriting guidelines"). Each application will be reviewed individually, and you will be notified if you are eligible for coverage and at which rate. You will also be notified if your application is denied.

*\*Underwriting guidelines are based on nationally recognized actuarial and clinical criteria.*

**Please note:** If you, your spouse or any dependent applying for coverage receives medical advice or treatment from a physician or other professional provider for a condition which is incurred *after* this application is signed but *prior* to the effective date of coverage, you must notify the Highmark Blue Cross Blue Shield Underwriting Department immediately at 120 Fifth Avenue, Suite 1224, Pittsburgh, PA 15222-3099. A change in your medical condition that occurs *prior* to your effective date could result in a denial of coverage if your application has not yet been approved or cancellation of coverage if your application has been approved but coverage is not yet effective.

## How to appeal a denial for insurance coverage

You have the right to appeal a denial for medical insurance. To do so, complete the following steps within 60 days of the date shown on the denial letter you receive:

- 1) Ask the attending physician to write a letter providing additional medical information about the condition(s) for which coverage was denied. Have the doctor include any pertinent clinical information to support your appeal.
- 2) Send the physician's letter, clinical information and a copy of the denial letter to:

Highmark Blue Cross Blue Shield  
PPOBlue Appeal  
Fifth Avenue Place  
120 Fifth Avenue, Suite 1224  
Pittsburgh, PA 15222-3099

Your appeal will be reviewed by a physician on our medical review staff, and a final decision will be issued to you in writing within 30 days.

## For more information or help completing this application...

If you have questions about this coverage or how to complete this application, please call a Member Service Representative at 1-800-876-7639.

# General Information:



An Individual Preferred-Provider High-Deductible Program

Utilizing the Keystone Health Plan West Network of Providers

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

- Check one:  I am applying for new Comprehensive Major Medical Preferred-Provider High-Deductible coverage (new applicant).  
 I am adding dependent(s) to my existing coverage.

If applying for husband and wife or family coverage, applicant must be the older spouse.  
 If children only are applying, youngest child must be the applicant.

(PLEASE PRINT) Applicant's Last Name		First Name	Middle Initial	County
Home Address		City	State	Zip Code
Home Phone Number (        )		Work Phone Number (        )		
Home E-mail		Work E-mail		

# Enrollment Information:

Annual deductible\* you prefer:  
 \$1,200 Individual/\$2,400 Family     \$2,600 Individual/\$5,200 Family     \$3,500 Individual/\$7,000 Family    \$ \_\_\_\_\_ Monthly premium

\*Please see Conditions of Enrollment (page 7) for information explaining how the Family Deductible works.

**Note:** Deductible level can be **increased** only on the contract anniversary date if the request is received prior to this date. Deductible level can be **decreased** as of the contract anniversary date only after the member holds a contract for two consecutive years and the request is received at least one month prior to contract anniversary date.

This Comprehensive Major Medical Preferred-Provider High-Deductible Subscription Agreement for Individual Members, Utilizing the Keystone Health Plan West Network of Providers, Without a Gatekeeper ("Agreement") renews on a month-to-month basis. The premium is payable in advance to Highmark Blue Cross Blue Shield on a monthly basis. Once enrolled, you can choose to pay your monthly premium via electronic funds transfer through the Pay It Easy program.

List spouse and/or eligible child(ren) you are enrolling. (Eligible children are unmarried children under age 19.)

	Self	Spouse	Child	Child	Child
Name					
Have you smoked or used smokeless tobacco within the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number					
Birth Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /
Present Age					
Sex					
Height					
Weight					
Current Physician					
Physician's Phone Number	(    )	(    )	(    )	(    )	(    )
HBCBS Use Only					

1. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have in force? This includes any current Highmark Blue Cross Blue Shield policy.  
 YES    If "yes," proceed to 1 (a) and (b).                       NO    If "no," proceed to question 2.

1 (a). If you answered "yes" to question 1, please provide the insurance company name and applicable group and identification number(s):  
 Company Name: \_\_\_\_\_  
 Group No: \_\_\_\_\_ Agreement or I.D. No.: \_\_\_\_\_

1 (b). If you answered "yes" to question 1, please complete the enclosed **Notice to Applicant Regarding Replacement of Accident and Sickness Coverage form** and mail it with your application.

2. Have you or any applicants ever applied and been rejected for any:                      Name or Person(s) Rejected and Reason  
 Medical policies                       Yes    No                      \_\_\_\_\_  
 Life Insurance policies               Yes    No                      \_\_\_\_\_

3. Are you or any of your dependents who are applying for this coverage enrolled in or eligible for Medicare due to age and/or disability?     Yes     No

ANY PERSON ELIGIBLE FOR MEDICARE OR MEDICARE DISABILITY BENEFITS IS NOT ELIGIBLE FOR THIS COVERAGE.

4. Payment Enclosed \$	Group Number <b>035000-00</b>	Applicant's Social Security Number
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# Medical Information:

## Section A.

Please answer each question completely. If it is found that you have supplied fraudulent information, or made fraudulent statements or omissions with the intent to deceive, your Agreement may be voided.

1. Do you – or any family member applying – use any medical equipment (such as a walker, wheelchair, cane, hospital bed, C-PAP, Bi-PAP and oxygen)?  Yes  No

2. Are you – or any family member applying – currently receiving home health care?  Yes  No

3. If you answered “YES” to question 1 or 2, please provide the name(s) of the affected person(s) and specifics about the condition:

Name of Person	Condition/Reason
_____	_____
_____	_____

4. Give date of last menstrual period for each female family member applying:

Name of Person	Date of Last Period
_____	_____
_____	_____

5. Have you — or any family member applying — been recently (i.e., within the past nine (9) months) medically diagnosed or treated for pregnancy?  Yes  No

Name(s) of pregnant person(s): \_\_\_\_\_ Date medically diagnosed or treated: \_\_\_\_\_

6. Have you – or any family member applying – gained or lost more than 20 pounds over the past 3 months?

Yes  No If “YES,” provide person’s name and amount gained or lost.

Name of Person	Weight Gained/Lost
_____	_____
_____	_____

## Section B.

For each person listed on this application, please check the block and enter the most recent date of diagnosis, treatment, monitoring or medical consultation by a physician or other health care provider for any condition, illness, injury or surgery.

Conditions	List Dependent(s) by Name				
	Applicant	Spouse			
7. AIDS or Positive Test for HIV, HTLV-III/LAV Antibodies					
8. Alcoholism					
9. Alzheimer’s Disease					
10. Amputation of Limb (Specify) _____					
11. Arterio-Venous Malformation (AVM)					
12. Arthritis (Specify type) _____					
13. Other Musculoskeletal Conditions (Specify - for example: osteoporosis or osteopenia) _____					
14. Asthma					
15. Back Disabilities					
16. Back Pain - Chronic					
17. Brain Tumor					
18. Cancer					
19. Cataract(s) right _____ left _____					
20. Chest Pain or Angina					
21. Chiropractic or Therapy Visits ( <b>Required</b> - Specify type and number of visits) _____					
22. High Cholesterol ( <b>Required</b> - Specify total cholesterol) _____					
23. Cirrhosis					
24. Other Liver Disease (Specify) _____					
25. Congenital Anomalies and Conditions (Specify) _____					
26. Dementia, “Senility” or Increasing Forgetfulness with Age					
27. Diabetes – Controlled with Diet ( <b>Required</b> - Specify current Hemoglobin A1c or Fasting Blood Sugar) _____					
28. Diabetes – Controlled with Medication ( <b>Required</b> - Specify current Hemoglobin A1c or Fasting Blood Sugar) _____					

# Medical Information (Continued)

Conditions	Applicant		List Dependent(s) by Name			
	Applicant	Spouse				
29. Disease/Surgery of the Esophagus, Stomach or Intestine (for example, Crohn's Disease, Ulcerative Colitis or weight loss procedures) (Specify) _____						
30. Drug Dependency						
31. Ear Conditions (including frequent ear infections) (Specify) _____						
32. Emphysema/COPD						
33. Other Lung Disease (Specify - for example, work-related conditions or chronic bronchitis) _____						
34. Gynecological (Specify - for example, polycystic ovaries _____ ) If recent delivery, please provide date of medical release (post-partum check-up) from Obstetrician/Gynecologist: _____						
35. Heart Attack						
36. Other Heart Disease/Irregular Heart Rate (Specify) _____						
37. Hepatitis						
38. High Blood Pressure ( <b>Required</b> - Specify last blood pressure reading) _____						
39. Infertility (Specify) _____						
40. Immunization for Children Name and address of pediatrician: _____ _____						
41. Kidney/Renal Failure						
42. Other Kidney Disorder (Specify - for example, kidney stones or cysts) _____						
43. Leukemia						
44. Other Hematologic (Blood) Disorder (Specify) _____						
45. Musculoskeletal (pertaining to muscle or bone) Injury or Illness (Specify) _____						
46. Neurologic Deficit or Disorder, including headaches, epilepsy ( <b>Required</b> - Specify date of last seizure), head or spinal injury or paralysis (Specify) _____						
47. Psychiatric Disorder/Behavioral Health						
48. Severe Injury or Burns (Specify) _____						
49. Severe Visual Impairment/Blindness						
50. Spinal Injuries						
51. Stroke						
52. Surgery of any kind (Specify) _____						
53. Temporomandibular Joint Syndrome (TMJ)						
54. Transient Ischemic Attacks (TIAs)						
55. Urological/Prostate/Bladder						
56. Please describe any other conditions, illnesses or injuries not specifically mentioned on this application for which you or your eligible dependents have been diagnosed, treated or monitored and for which you or your eligible dependents are receiving ongoing evaluation, treatment or monitoring by a physician or other health care provider. For example: • Thyroid Condition • Sleep Disorder • Hormone Therapy • Skin Condition (Psoriasis, Dermatitis) • Polyps (Specify) _____	_____ _____ _____ _____ _____					

Please note: Any physician charges or other fees incurred during the process of completing this application are the responsibility of the applicant.

# Medical Information (Continued)

## Section C.

If any of the conditions in Section B are checked, please explain below. Use additional paper if necessary. Please provide details of the condition.

Name/Condition/ Treatment	Most Recent Date Of Treatment Monitoring or Medical Consultation by a Physician or Health Care Provider	Attending Physician	Dates of Illness
57.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: (    ) _____ Hospital Name: _____	From: _____ To: _____
58.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: (    ) _____ Hospital Name: _____	From: _____ To: _____
59.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: (    ) _____ Hospital Name: _____	From: _____ To: _____

60. When was the last time each person applying for coverage visited a doctor (other than at an emergency room)? Include date of visit, name and address of physician or other provider (gynecologist/obstetrician, osteopath, chiropractor, etc.) and reason for visit. Use additional paper if necessary. **This question must be answered.** If it is not answered, the application will be considered incomplete and returned to you for additional information.

Applicant: \_\_\_\_\_ Date of Exam \_\_\_\_\_

Provider's Name and Address \_\_\_\_\_

\_\_\_\_\_

Reason \_\_\_\_\_

Spouse: \_\_\_\_\_ Date of Exam \_\_\_\_\_

Provider's Name and Address \_\_\_\_\_

\_\_\_\_\_

Reason \_\_\_\_\_

Dependent Child: \_\_\_\_\_ Date of Exam \_\_\_\_\_

Provider's Name and Address \_\_\_\_\_

\_\_\_\_\_

Reason \_\_\_\_\_

Dependent Child: \_\_\_\_\_ Date of Exam \_\_\_\_\_

Provider's Name and Address \_\_\_\_\_

\_\_\_\_\_

Reason \_\_\_\_\_

# Medical Information (Continued)

61. When was the last time each person applying for coverage visited an emergency room at a hospital or other medical facility? Include date of visit, name and address of emergency room, attending physician's name and reason for visit. Use additional paper if necessary.

Applicant: \_\_\_\_\_ Date of Visit \_\_\_\_\_

Hospital Name and Address \_\_\_\_\_

Physician \_\_\_\_\_

Reason \_\_\_\_\_

Spouse: \_\_\_\_\_ Date of Visit \_\_\_\_\_

Hospital Name and Address \_\_\_\_\_

Physician \_\_\_\_\_

Reason \_\_\_\_\_

Dependent Child: \_\_\_\_\_ Date of Visit \_\_\_\_\_

Hospital Name and Address \_\_\_\_\_

Physician \_\_\_\_\_

Reason \_\_\_\_\_

Dependent Child: \_\_\_\_\_ Date of Visit \_\_\_\_\_

Hospital Name and Address \_\_\_\_\_

Physician \_\_\_\_\_

Reason \_\_\_\_\_

Dependent Child: \_\_\_\_\_ Date of Visit \_\_\_\_\_

Hospital Name and Address \_\_\_\_\_

Physician \_\_\_\_\_

Reason \_\_\_\_\_

# Medical Information (Continued)

## Section D.

If you — or any family members applying —

62. — Drink alcoholic beverages, please indicate frequency of use:

Name of Person

Number of Drinks per Week

(Serving size per drink equals 1½ oz. liquor, 12 oz. beer, 5 oz. wine)

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63. — Have, within the last year, used tobacco products, please indicate amount of cigarettes, cigars, pipes or smokeless tobacco (snuff, chewing tobacco, etc.) used and length of use:

Name of Person

Amount per Day/Type

Dates of Use

Name of Person	Amount per Day/Type	Dates of Use	
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:

64. — Have taken prescribed drugs within the last year, please list drug(s) taken and reason:

Name of Person

Medication/Dosage

Dates of Use

Condition/Reason

Name of Person	Medication/Dosage	Dates of Use		Condition/Reason
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	



Highmark Inc. d/b/a  
Highmark Blue Cross Blue Shield  
120 Fifth Avenue  
Pittsburgh, PA 15222-3099

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Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. PPOBlue is a service mark of the Blue Cross and Blue Shield Association.

# Conditions of Enrollment

I, the undersigned, hereby apply for coverage for myself and all my listed eligible dependents.

I represent, to the best of my knowledge and belief, that:

1. I have read and have supplied all the requested information on this form with regard to myself and any family members applying for coverage. (If not, I have attached a letter which explains why.)
2. All applicants for this policy are in good health except for those conditions listed in the Medical Information portion of the application.
3. No material information has been withheld or omitted about the past or present state of my health or any family member(s) applying.

I understand and agree that:

1. Any person eligible for Medicare or Medicare disability benefits is not eligible for this coverage.
2. This coverage does not begin until this application is accepted by Highmark Blue Cross Blue Shield and an Effective Date of coverage is assigned; and
3. Initial payment must be submitted with the application; and
4. Receipt of my money (check or money order) does not constitute enrollment under any program; and
5. This coverage is provided only to residents of the geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield. We reserve the right to investigate and confirm your residence from time to time.
6. If applicant is under age 18, the signature of a parent or guardian is required on this application.

I also understand and agree that Highmark Blue Cross Blue Shield may:

1. Require me and any family member(s) applying to provide upon request medical history or to have a medical examination, blood test or other applicable medical test prior to acceptance of the application (Highmark Blue Cross Blue Shield may choose to specify the provider);
2. Deny this application, in which case any premium submitted will be refunded and accepted by me; or
3. Void this Agreement (health insurance policy) or deny a claim for loss incurred or disability (as defined in the Agreement) during the first three (3) years from the effective date of this Agreement if the applicant made a material misrepresentation of a material fact in the application that affected the risk or hazard assumed by the Plan.
4. Void this Agreement or deny a claim for loss or disability (as defined in the Agreement) after three (3) years from the Effective Date only for fraudulent material misstatements made by the applicant in the application for such Agreement.

I also understand and agree that the Agreement will not provide benefits for me or any enrolled dependents during the 12-month period following the Effective Date on which I and any dependents become enrolled under the Agreement for any condition for which medical advice or treatment was recommended by or received from a physician within a five-year period prior to the Effective Date of the Agreement.

I understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Highmark Blue Cross Blue Shield and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of

that Agreement, to administer the program. I recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations.

A copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

To the best of my knowledge and belief, the information provided on this application is true and correct.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**I request this coverage to become effective \_\_\_\_\_.**

**Your requested Effective Date must be within two (2) months of your date of signature below.**

Note: The Effective Date of coverage is usually the first day of the month following medical underwriting approval. However, we cannot guarantee that your requested Effective Date can be met. The Effective Date is in all cases the date on which your coverage begins following medical underwriting approval and assignment of an Effective Date.

Please note: To avoid delays in processing your application, this form must be received by Highmark Blue Cross Blue Shield within fifteen (15) days of the date of your signature.

**Please initial, sign and date where requested below. If you and your spouse are applying for this coverage, your spouse also must read and understand these "Conditions of Enrollment," and initial, sign and date where requested below.**

**\*Family Deductible: For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met (within a benefit period) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.**

**I understand and accept that, under the terms of the PPOBlue Agreement, when more than one (1) family member is covered, one (1) or more family member(s) must satisfy the ENTIRE family deductible (within a benefit period) before Highmark will pay for covered services for ANY individual family member.**

**Please initial here to indicate you have read and understand the explanation of the Family Deductible.**

**Applicant's Initials \_\_\_\_\_ Spouse's Initials \_\_\_\_\_**

This program is available to individuals who wish to purchase a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service.

Applicant's Signature	Date
Spouse's Signature	Date

